Cigna

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7SIASO51-1
CR7SIASO52-1

Policyholder: Rutherford County Employee Benefit Trust

Rider Eligibility: Each Employee as reported to the insurance company by your Emloyer

Policy No. or Nos. 3321836-OAP2, OAP2R

EFFECTIVE DATE: January 1, 2014

You will become insured on the date you become eligible if you are in Active Service on that date or if you are not in Active Service on that date due to your health status. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above.

Anna Krishtul

Anna Krishtul, Corporate Secretary

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The sections entitled **Calendar Year Deductible**, **Out-of-Pocket Maximum** and **Emergency and Urgent Care Services** in THE SCHEDULE — **Open Access Plus Medical Benefits** — in your certificate are changed to read as attached.

THE SCHEDULE — **Prescription Drug Benefit**— section in your certificate is changed to read as attached.

The definition in your certificate entitled "**Dependent**" is replaced by the definition attached to this certificate rider.

Open Access Plus Medical Benefits

The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	$500 per person	$1,000 per person
Family Maximum	$1,000 per family	$2,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		
Out-of-Pocket Maximum		
Individual	$2,500 per person	$5,000 per person
Family Maximum	$5,000 per family	$10,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	80% after plan deductible	80% after plan deductible
Hospital Emergency Room	No charge after $300 per visit copay* and plan deductible *waived if admitted	No charge after $300 per visit copay* and plan deductible *waived if admitted
Outpatient Professional Services (radiology, pathology and ER Physician)	No charge after plan deductible	No charge after plan deductible
Urgent Care Facility or Outpatient Facility	80% after plan deductible	80% after plan deductible
X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit)	No charge after plan deductible	No charge after plan deductible
X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	80% after plan deductible	80% after plan deductible
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge after plan deductible	No charge after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) for ER	No charge after plan deductible	No charge after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) for UC	80% after plan deductible	80% after plan deductible
Ambulance	80% after plan deductible	80% after plan deductible

Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drugs and Related Supplies for which no payment is provided because of the Coinsurance factor and any Copayments or Deductibles. When the Out-of-Pocket maximum shown in The Schedule is reached, benefits are payable at 100%.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Out-of-Pocket Maximum		
Individual	$1250 per person	Not Applicable
Family	$2500 per family	Not Applicable
Retail Prescription Drugs	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1		
Generic* drugs on the Prescription Drug List	No charge after $5 copay	In-network coverage only
Tier 2		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	20%	In-network coverage only

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	35%	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company Network 400 applies. Member can obtain a 90 day supply at retail through network 400 pharmacies only. Preventive Generics are covered at $0 member cost share.		
Home Delivery Prescription Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1 Generic* drugs on the Prescription Drug List	No charge after $12 copay	In-network coverage only
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	15%	In-network coverage only
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	30%	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company Preventive Generics are covered at $0 member cost share.		

Definition

Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a stepchild, a foster child, or a child for whom you are the legal guardian.

Dependent Spouse: A legally married spouse; Article XI, Section 18 of the Tennessee Constitution provides that a marriage from another state that does not constitute the marriage of one man and one woman is “void and unenforceable in this state.

Benefits for a Dependent child will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.